Medical Reengineering Initiative (MRI)

Newsletter, Issue 6 - April 2005

Our Army & AMEDD Supporting a Nation at War…Relevant & Ready

A Campaign Quality Army with Joint & Expeditionary Capabilities

Director's Corner

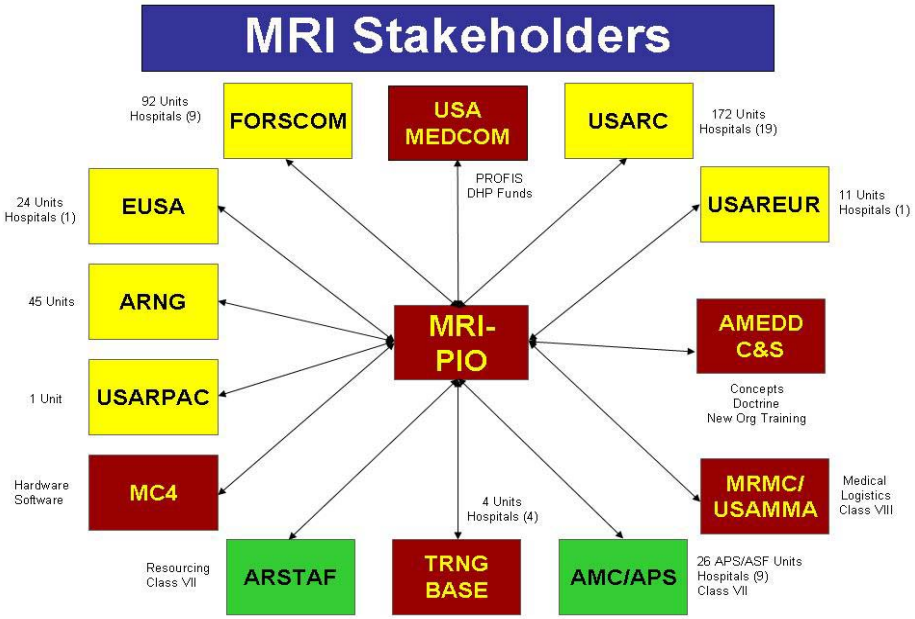
By Colonel Angel L. Lugo,
MRI Program Director

Here is another informative newsletter aimed at our units undergoing MRI conversions and activations. This 3d Qtr, FY 05 volume is a special newsletter since it provides me the opportunity to further update you on MRI activities while bidding farewell as I transition to new endeavors by taking command of the 212th MASH in Germany. We included several new articles, continued our recurring column, and updated our contacts and upcoming activities. First, LTC Weingarten provides you some feedback from our Reserve Component unit assistance visits, describes some of the MRI unit characteristics, and addresses some of the impacts of unit conversions on mission accomplishment and retention. Second, LTC Stocker and Mr. Spencer tie together Army and AMEDD logistics transformation including a brief overview of our transforming medical logistics units. Third, we feature the duties and responsibilities of the ARNG Med OI as we complete our series on these very important AMEDD officers from the force structure world. Lastly, our Senior Operations Analyst focuses on the readiness pillar of integration in his article entitled "Unit Status Reporting and Your Force Structure Change: What You Need to Know".

Note that the MRI Program status had some changes since the recently published Army Structure message documented the decisions of the Modular Support Force Analysis (MSFA) which we refer to as "TAA 11.1". Our overall program completion is now at 42% for our endstate manned units though there are many unit actions still to occur in this FY. Also note that the Adaptive Medical Increments (AMI) will soon pick up steam as the AMEDD Center & School plans to continue the formal TOE development process for new Battle Command organizations and other critical unit types. The AMI is an important refinement of the MRI force design update and represents the next generation of our modular medical forces.

As I bid farewell early, I want to thank all of the MRI stakeholders and partners shown in the figure below for all of their collaborative efforts in ensuring successful MRI unit actions. I extend additional thanks to the MED OIs for their dedicated support to MRI actions across the entire Army. Finally, I say special thanks to the MRI staff for their unyielding, excellent staff work across the full spectrum of MRI and AMEDD actions.

In closing, as I join the team converting the 212th MASH to an MRI CSH (Corps) and move from planning to executing MRI, I know that our future modular medical force is in the hands of a great staff guided by engaged AMEDD leaders. Thanks to all – it has been a great ride!



MRI Reserve Component Notes

By LTC Charlene Weingarten, MRI Deputy Director for Reserve Affairs

Over the past six months I have had the pleasure of visiting several Reserve Component (RC) medical units to conduct MRI Unit Assistance Visits (UAV) as well as opportunities to brief the MRI program status at various forums. Two of the questions that are continuously asked at some of these sessions are: How do we execute MRI conversion? How do we retain soldiers?

The following are some of the reactions I have observed while conducting visits and briefings. There is a perception by many soldiers and senior leaders that MRI is a downsizing versus reorganizing initiative. Also, there are concerns about units being expected to "do more with less" as one Sergeant Major commented. Additionally, there is concern that Soldiers will be "burned out" by the (perceived) increased workload and multiple deployments thus leading to retention issues. Since frequency of deployments are operational concerns, I would like to take this opportunity to reemphasize what MRI brings to the AMEDD.

The MRI organizations are designed to meet the Army's changing patterns of operation, correct organizational deficiencies and support the vision of the Army Transformation. MRI directly supports several Army focus areas: Modularity, Joint Expeditionary Mindset, Active Component/ RC Balance, Focused Logistics, and The Soldier. Some key characteristics of MRI units are:

- Improved smaller, tailorable, independent, modular, capabilities-based organizational designs
- Organized for split-base operations
- Increased tactical mobility
- Reduced medical footprint
- Improved communications capability
- Enhanced information management/ information technology capability.

These characteristics allow Medical Planners to package the combat health support capabilities in a manner that supports the mission and avoids sending excess capability into theater. This reduction in structure translates into a reduced medical footprint in a theater of operations, but not "doing more with less". It means performing the mission successfully with the right number and right mix of personnel and equipment.

The Army Medicine White Paper dated 09 March 2005 stated: "AMEDD Transformation embraces the fact that every Soldier, active and reserve, is deployable and it blurs the historical distinction between the Table of Distribution and Allowances (TDA) and Table of Organization and Equipment (TOE) units' functions." Therefore, medical units must not only be trained in their clinical specialties, but also in their tactical/survival skills. I fully understand command and staff concerns regarding retention, but I would have to say that unit deployments are a certainty and a situation that a soldier must accept. Our Army is serving a nation at war and a large percentage of medical support for the Active Army lies within the RC. It is through committed, competent leadership and tough realistic training that the Army Reserve and Army National Guard will ensure success in all future endeavors; and it will require a deep and enduring commitment from every member of the RC!

Transforming Medical Logistics

By LTC Vikki L. Stocker, MRI Deputy Program Director /Mr. Kenneth Spencer, Sr. Per Analyst

Greetings. This article will update you on the status of the transformation and force design update of medical logistics field units. According to LTC Victor Maccagan, Jr., in his January 2005 article, *Logistics Transformation- Restarting A Stalled Process*, The Army Logistics Transformation is pivotal to the successful transformation of the force. He noted that the key component of logistics transformation is the modular redesign of echelon above division combat service support organizations.

The transformation of medical logistics units is essential to the AMEDD transformation, and includes modularity as a basic tenet. However, as you will see below the job is well started, but not complete.

The current force of Medical Force 2000 (MF2K) logistics units consist of a Theater Medical Material Management Center (TMMMC); Medical Logistics Support Detachment; Medical Logistics Battalion (Med Log Bn) (Forward) and Med Log Bn (Rear), both with a Log Support Company, Distribution Company, and an embedded Blood Platoon.

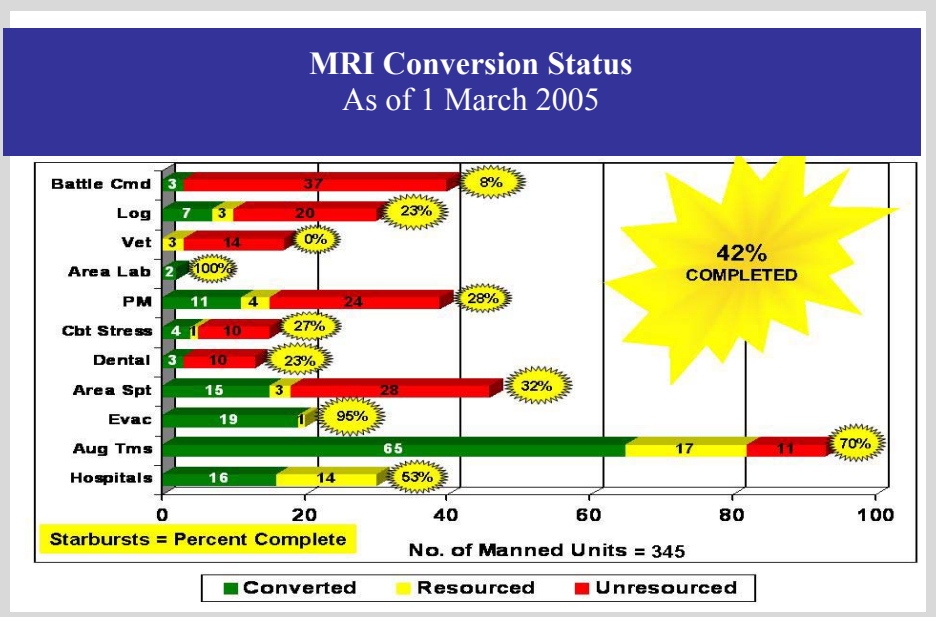
Under MRI, the MF2K Med Log Bns are converting to the MRI Med Log Co, Med Log Spt Co and Blood Detachment. The Multifunctional Med Bn will be the Battle Command for these units. Also, the TMMMC converted to the Med Log Mgmt Ctr and the Med Log Dets are eliminated from the force design. The MRI Med Log units provide the following in terms of modularity:

- Split-based operation for CLVIII and medical maintenance
- Three deployable medical maintenance support teams.
- Deployable 5-person forward distribution blood augmentation cell.
- Deployable 5-person mobile forward support cell
- Single-Integrated Medical Logistics Manager

As of 1 Mar 05, seven of 30 MF2K logistics units converted to MRI (23%) consisting of 5 of 17 active and 2 of 13 Army Reserve. Also, three more active units are resourced to convert to MRI. In summary, The AMEDD will continue to transform medical units to keep pace with Army modularity force initiatives. Several MRI units have transformed to the Adaptive Medical Increment (AMI). The AMI concept further modularizes these organizations into more flexible capabilities. The next AMI Force Design Update to be forwarded to DA for approval will include MRI Med Log units.

MRI Program Status

As of 1 March 2005, 42% (145 of 345 manned units) of the MRI Modular Support Force Analysis Force Structure converted to MRI. This is a seven percent reduction from last quarter, and due to force structure initiatives associated with the Modular Support Force Analysis. The number of MRI unit decreased from 376 to 345, primarily due to the move of Air Ambulance Companies now being organic to the General Support Aviation Battalions. The chart below depicts the MRI conversion status for units in each of the 10 medical functional areas.



In the Spotlight

Organization Integrators (OI) - Head of an organization integration team which manages the resourcing, documentation, fielding, and sustainment of functionally similar organizations as integrated packages assuring doctrinally aligned capabilities within resource constraints. The Medical OIs play a major role in the MRI program. The Medical OIs and staffs (as applicable) are located at Army G3, FORSCOM, USARC, ARNG and other MACOMs. This newsletter will feature the major duties and responsibilities of the last Medical OI— the ARNG Medical OI— and conclude our feature on Medical OIs.

Army National Guard Med OI Major Duties:

- Represent ARNG at HQDA and MACOM level conferences on all medical force integration issues, including inactivations, reorganizations and conversions.
- Manage continuous analysis of the current and projected AMEDD force and prepare options and recommendations for the ARNG on medical decisions during all phases of the TAA process.
- Maintain liaison with NGB, states and territories, FORSCOM, MEDCOM and AMEDD C&S to stay abreast of current, future developments and actions; provide an ARNG influence in issues that focus on the ARNG medical force.
- Monitor and stay abreast of the MRI process and coordinate actions on all ARNG Force Structure issues.
- Provide pertinent information for FVC reviews and respond to ARNG taskers.

Pillars of Force Integration

The MRIPIO, along with the MACOMs, assess the nine pillars of force integration to determine a unit's ability to meet minimum DA standards for readiness prior to converting/ activating as MRI. Each of these pillars will be highlighted in subsequent newsletters. Newsletter Issue #4 discussed stationing and #5 discussed equipping. This newsletter will highlight readiness.

Nine Pillars	
Structuring	Equipping
Training	Manning
Sustaining	Deploying
Stationing	Funding
Readiness	

Readiness. Unit Status Reporting and Your Force Structure Change: What You Need to Know.

The Army's Unit Status Report (USR) system (AR 220-1) enables commanders of reporting organizations, across the Army, to uniformly determine and accurately report an overall level of readiness with respect to personnel availability, equipment on hand/ ready and training proficiency. More importantly, this information supports deliberate and crisis response planning, and management responsibilities to organize, train and equip forces. There are five (5) overall readiness levels (C-1, C-2, C-3, C-4, C-5) and Level 6. These levels are defined as follows: C-1 - unit can undertake the full range of combat missions; C-2 - unit can undertake most of it's combat missions; C-3 - unit can undertake many, but not all of it's combat missions; C-4 - unit requires additional resources (people, equipment, training) to accomplish it's combat mission; and C-5 - unit is undergoing a service-directed structure change or resource action and is not prepared, at this time to undertake the combat mission. These readiness levels will be discussed in greater detail later. Level 6 indicates that one or more of the measured areas are not measurable. The HQDA standard for any unit activating or converting is C-3 or higher. Question: What is the most reliable policy or procedure that can be incorporated at the unit, senior headquarters or MACOM level to promote the required readiness level at conversion or activation Effective Date (EDATE)? Answer: The requirement to submit a "Shadow USR" starting at least 120 days prior to the EDATE. A Shadow USR is the same document that units are required to submit using PC-ASORTS monthly (quarterly for RC units). The only difference is all computations are based on the unit's new (conversion or activation) MTOE vice the unit's current MTOE. It is also important to note that submission of a Shadow USR is in addition to the unit's routine USR submission. By initiating and submitting Shadow USRs several months out from EDATE, unit commanders, senior command headquarters or the MACOMs will be able to identify resource shortfalls in sufficient time to adjust priorities and provide the appropriate level of resourcing required for a unit to meet the HQDA standard at EDATE.

The objective of the Army force development process is to transform the force without significantly degrading unit readiness. Therefore, these actions must be synchronized with and complemented by the availability of personnel and equipment. Though we know that all resources required to support a new unit structure should be available at or before the unit's EDATE, we also know that as we continue to pursue the GWOT, both personnel and equipment will be in higher demand. The current resource constrained environment makes the early submission of a Shadow USR more and more critical. If a unit commander can project, based on calculations on the Shadow USR, that the unit will not make the minimum HQDA standard (C-3 or greater) at EDATE, or when a converting unit reaches Level 4 in any readiness area, the unit can request and MACOMs must approve the unit submitting a USR overall readiness rating of C5. In fact, AR 220-1 clearly states that: "MACOMs will direct units undergoing activations/conversions at an overall level of less than C-3 to report C-5 until they attain a minimum level of C-3 in all measured areas". The measured areas are: (P-level = personnel, S-level = equipment on hand, R-level = equipment readiness and T-level = training). Using C-5 begins with the first report after EDATE. The maximum time period a unit can report C-5 is one year for AC units and three years for RC units. Also, it is important to note that after a unit has reached and reported C3 or greater on the USR, the unit

must report C-4 and not C-5 if the unit status subsequently deteriorates below the C-3 level.

So far we have only discussed force structure changes which are activations or conversions. USR reporting also is impacted by units programmed to inactivate. The MACOMs may direct units programmed for inactivation to report C-5 when the unit reaches Level 4 in any measured area and is within 365 days of the inactivation EDATE. The unit must possess orders directing the action or be on a HQDA approved Command Plan (RC only), and have a confirmed EDATE. All units will report C-5 at 90 days prior to the EDATE and continue to report it until the unit is inactivated. Moreover, in the current resource scarce environment, personnel and equipment in these inactivating units would be available for reprogramming to other higher priority units with no significant readiness impacts on the inactivating unit.

Finally, I hope this article provided you insight on what the USR does for the unit and the Army. The Army's unit status objective is to develop and maintain units at optimum status levels considering GWOT requirements and available resources.

Updates & Activities

The MACOM/MRI Unit Assistance Team

The MRI Unit Assistance Team continues to visit units two and one years prior to their MRI activation/ conversion EDATES. The MACOM led team completed successful unit visits to Ft. Bragg, NC and Puerto Rico. Each Unit Assistance Visit is designed to address issues and concerns pertaining to the nine pillars of force integration. The Program Director thanks the Med OIs for their support in making these visits a success. Our next major visit is to the 1st Med Bde and Ft Hood, TX.

Activities 3rd Quarter (3QTR) FY2005)

Several activities are scheduled for 3QTRFY05 regarding MACOM/MRI visits, NOT training, and USAMMA fielding as indicated above:

MACOM/MRI Visits

Date (2005)	Unit	Location	Remarks
5-7 Apr	1077th ASMD	Salina, KS	Confirmed
11 Apr	RTS-Med Cdrs	Reno, NV	Confirmed
16-17 Apr	8th Med Bde Symp	Ft Hamilton, NY	Confirmed
Apr 05	926th PM Det	Ft Benning, GA	Coordinating
9-11 May	1st Med Bde	Ft Hood, TX	Confirmed
3-5 Jun	865th CSH	Niagara Falls, NY	Confirmed
Jun	172nd PM Det	HAAF, GA	Coordinating
Jun	212th CSC Det	Ft Campbell, KY	Coordinating

New Organization Training

Date (2005)	Unit	Location	Remarks
8-10 Apr	466th ASMC	Glens Fall, NY	Confirmed
11-13 Apr	1st & 9th AMLs	APG, MD	Confirmed

POCs at AMEDDC&S, Department of Training Support:

Mr. Don Begley, NOT Trainer, DSN 421-9237 or Commercial (210) 295-9237
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USAMMA Fielding

Date (2005)	Unit	Location	Remarks
2 Apr	314th MCD	Chester, VT	Confirmed
10 Apr	318th MCD	Bossier City, LA	Confirmed
10 Apr	302nd MCD	Bossier City, LA	Confirmed
9 May	336th MCD	Millington, TN	Confirmed
20 May	378th MCD	Saco, ME	Confirmed
13 Jun	272nd MCD	Garden Grove, CA	Confirmed
13 Jun	349th CSH	Los Angeles, CA	Confirmed
22 Jun	144thMCD	San Diego, CA	Confirmed

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Note: This schedule is tentative and subject to change.

Future Newsletter Topics

- Pillars of Force Integration—Manning
- MRI and Task Force Medical Initiatives
- New AMEDD Battle Command Organizations

Give Us Your Feedback…

We hope that this sixth publication of the MRI Newsletter provided useful information to you about the MRI Program and associated activities. Please forward your feedback on this issue and topics you desire to see in future MRI Newsletters to: kenneth_e_spencer@belvoir.army.mil.

Also, refer to the MRI Points of Contact, MRI Website URL and MRI Knowledge Collaboration Center for additional information.

MRI Points of Contact

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MRI Website

The URL for the website is:
http://mrimedforce.belvoir.army.mil

MRI Knowledge Collaboration Center (KCC)

To request access, submit email to:

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- DSN: 656-0652